

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-5

CERTIFICATE OF DEATH

12278

Reg. Dist. No. 2420

1. PLACE OF DEATH:

County Prince Georges
City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
1004-64 Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland
City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1004-64 Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

William Joseph Abrams (Abrams)

3. (b) Social Security Number

4. Sex Male 5. Color or race Caucasian 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Sadie Abrams

7. Birth date of deceased (mo., day, yr.) April 12 1902 6.(c) If alive, give age 40 years

8. AGE: Years 44 Months Days If less than one day hrs. min.

9. Birthplace Prince Georges Co. Md.
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Coarse Lumber yard

12. Name Daniel Abrams

13. Birthplace Prince Georges Co. Md.

14. Maiden name Hattie Abrams

15. Birthplace Prince Georges Co. Md.

16. Informant Agnes Abrams

Address 6411 Jay St. - Cedar Heights Md.

17. Burial Date thereof Dec. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moses Cemetery

Location Anne Grundel Co., Ind.

18. Funeral director Hennys Washington & Sons

Address 467 N. St. N.W. Wash., D.C.

19. 12/24 19 46 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 19 46 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 19 46 to Dec. 22 19 46 and that I last saw him alive on Dec. 22 19 46

Immediate cause of death

Acute Toxic
Due to myocarditis

Due to Influenza

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE H.T. Beeson, MD.

M. D. or other

Address 423 Hunt Pl. NE

12-22-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

12279
Reg. Dist. No. 2431

1. PLACE OF DEATH;
County Prince Georges
City or town Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6313 16th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

ELLEN M. BAILEY

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Rudolph Bailey
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 9, 1883
8. AGE: Years 63 Months 3 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Jeremiah Fahey
13. Birthplace County Claire, Ireland

MOTHER 14. Maiden name Bridget McNamara
15. Birthplace County Claire, Ireland

16. Informant Deceased
Address _____

17. Removal Date thereof Dec 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
Location to Washington, D.C.

18. Funeral director Thomas B. Haulon
Address 641 24th St. N.E.

19. Dec 28, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28th 1946, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22 1946 to Dec 28th 1946
and that I last saw him alive on Dec 28th 1946

Immediate cause of death _____ DURATION 1 mo.
Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other _____Address Glenn Dale Md Date signed 12/28/46

RECEIVED
JAN 4 1947
BUREAU OF

2-25

2-2430 ————— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15705

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince George
 City or town Sandston, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred:
2 Ardmore Road
 How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Sandston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Ardmore Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war name

3.(a) FULL NAME

CAROL BAKER

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Infant
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Dec. 5, 1945
 8. AGE: Years _____ Months 11 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER 12. Name Robert C. Baker

13. Birthplace _____

14. Maiden name Marion Planabe

15. Birthplace _____

16. Informant Marion Planabe

Address Watts Road General Hosp.

17. Burial Date thereof 12-2-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ar. Natl. Cemetery

Location St. Mary's, Virginia

18. Funeral director Mr. W. Chambers Co.

Address Riverside, Maryland

19. 12/2 1946 Amanda Dourney
 (Date fee'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946 at 10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to Dec 1 1946 and that I last saw him alive on Nov 30 1946

Immediate cause of death _____ DURATION

Hydrocephalus 3 mo

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE John D. Maloney, M.D.
 M. D. or other _____

Address Chesley, Maryland Date signed 12-2-46

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DEC 4 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12281

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County..... Prince Georges
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 year, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1621 Q. St., S. E.
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

CAROLYN B. BASS.

3. (b) Social Security Number

577-10-5509

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ray Bass

7. Birth date of deceased (mo., day, yr.) July 4, 1918 6. (c) If alive, give age 36 years

8. AGE: Years 28 Months 28 Days 5 If less than one day hrs. min.

9. Birthplace Charles Co., Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Theodore Sinclair 13. Birthplace Charles Co., Maryland

MOTHER 14. Maiden name Maude Oliver 15. Birthplace Charles Co., Maryland

16. Informant Deceased Address

17. Removal to Date thereof Dec 9, 1946 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington, D.C.
Location

18. Funeral director J. William Lee's Sons Co.
Address 300-4 St NE Washington D.C.

19. Dec 9, 1946 Rowland S. Philips Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9, 1946, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21, 1946, to Dec 9, 1946, and that I last saw her alive on Dec 9, 1946.

Immediate cause of death Pulmonary Tuberculosis DURATION 1.6 mo.

Due to Tuberculous Laryngitis
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinecone M.D. M. D. or other
Address Glenn Dale, Md. Date signed 12-9-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12282

Reg. Diat. No. 2431

1. PLACE OF DEATH:

County Prince Georges
City or town Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 28 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 8 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1532 9th St., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

JERRY BATTLE

3. (b) Social Security Number

579-20-5683

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Ruth Battle

6. (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1916

8. AGE: Years 30 Months 30 Days 10 If less than one day 9 hrs. 9 min.

9. Birthplace Rocky Mount, North Carolina
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

12. Name Louis Battle

13. Birthplace Rocky Mount, North Carolina

14. Maiden name Annie Boddie

15. Birthplace Rocky Mount, North Carolina

16. Informant Deceased

Address

17. removal Date thereof Dec 2 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Washington D.C.

Location " "

18. Funeral director W. Ernest Jarvis Co

Address 1432 - Glen St.

19. Dec 2 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 2 1946 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR 4, 1946 to DEC 2, 1946 and that I last saw him alive on DEC 2, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 15 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane MD M. D. or other

Address Glenn Dale, Md. Date signed 12/2/46

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 11 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B6*

CERTIFICATE OF DEATH



Reg. Dist. No. *1322431*

1. PLACE OF DEATH:

County *Prince Georges*
City or town *Glenn Dale, Maryland*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *2 mos., 19 days.*
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? *2 mos., 19 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *D. C.* County _____
City or town *Washington*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *4027 Beecher St., N. W.*
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

BEATON GEORGE

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*
6. (b) Name of husband or wife *Ida M. Beaton*
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) *May 4, 1866*
8. AGE: Years *80* Months *80* Days *7* If less than one day _____ hrs. _____ min.

9. Birthplace *Washington, D. C.*
(Town, county, and state)
10. Usual occupation *Government Clerk*
11. Industry or business *Customs Officer, Government*

FATHER
12. Name *Faulkner Beaton*
13. Birthplace *Scotland*
MOTHER
14. Maiden name *Lydia Ungerer*
15. Birthplace *Bucks Co., Pennsylvania*

16. Informant *Deceased*
Address _____

17. *Removal* Date thereof *12-10-46*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory *to Washington DC*
Location _____

18. Funeral director *James T. Ryan Inc*
Address *317 Pa Ave S E*

19. *12-10-46* *Rowland S. Phillips*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 9, 1946* at *6:00 p.m.*
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *9/20* *1946* to *12/9* *1946*
and that I last saw him/her alive on *Dec 9, 1946*

Immediate cause of death *pulmonary tuberculosis*
DURATION *5 mrs.*

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results *Bilateral pulmonary tuberculosis with*
PHYSICIAN: Please underline the cause to which death should be charged statistically *tuberculosis*

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE *Daniel Leo Pinecone MD*
Address *Glenn Dale, Md.* Date signed *12/9/46*

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1946

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2-2420 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

12284

★ Reg. Dist. No. 2450

1. PLACE OF DEATH:

County Prince George
City or town Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2-2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind County Pro Geo Co.
City or town Mt Rainier Ind
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3602 Barker Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Lucy Jane Poe Blandy

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Herbert W Blandy
6.(c) If alive, give age 88 years
7. Birth date of deceased (mo., day, yr.) aug 17 1862
8. AGE: Years 94 Months 4 Days 1 If less than one day
hrs. min.

9. Birthplace Ill.
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Wm R Poe
13. Birthplace Ind
14. Maiden name Mary?
15. Birthplace Ind

16. Informant Herbert Blandy

Address 3602 Barker Hill Rd Mt Rainier Ind

17. (Burial, cremation, or removal, Which?) Burial Date thereof Dec 27 1946
(month) (day) (year)

Cemetery or crematory Forest Lincoln

Location Col a manor ind

18. Funeral director H. Gasch's Sons

Address Huntsville ind

19. (Date rec'd by registrar) Dec 27 46 Registrar Jan Sevy

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Nov 25 1946
and that I last saw him alive on Dec 24 1946

Immediate cause of death Heart failure (Congestive) DURATION 1 day

Due to myocardial infarction ? yrs

Due to Senility

Other conditions arteriosclerosis
Myocardial infarction
(Include pregnancy within 3 months of death) 40 years

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm R Poe M. D. or other

Address 3602 Barker Hill Rd Date signed 12/27/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

12285
263 21
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince GeorgesCity or town Woodbridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Woodbridge
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(d) If veteran, name war _____

3. (a) FULL NAME

Alice Brown

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Peter Brown

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age _____ years

18 7 9

8. AGE:

Years

Months

Days

If less than one day

67

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

from home

MOTHER FATHER

12. Name

John Brown

13. Birthplace

Maryland

14. Maiden name

Agnes Brown

15. Birthplace

Maryland

16. Informant

Moses Brown

Address

Woodbridge, Maryland

17. Burial, cremation, or removal (which?)

Date thereof

Dec 28 1946
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Clinton, Md.

18. Funeral director

J. B. Johnson

Address

Washington

19.

Dec 27 1946
(Date rec'd by registrar)

19

P. B. Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

acute congestive heart failure
cardiovascular renal disease

DURATION

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

James J. Smith

D. O. C.

Address Freshville, Md. Date signed 12-23-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

12286
245

1. PLACE OF DEATH

County Pro Geo Co
 City or town Hyattsville Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo Co
 City or town Hyattsville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4187- Hamilton st
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louie Fuller Carr

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

G. Hodges Carr

7. Birth date of deceased (mo., day, yr.)

Aug 12, 1871

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

71

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Wm H. Fuller

13. Birthplace

Washington D.C.

14. Maiden name

Josephine Peter

15. Birthplace

Washington D.C.

16. Informant

G. Hodges Carr

Address

Hyattsville Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Dec 24, 1946
(month) (day) (year)

Cemetery or crematory

St James

Location

Tracy's Landing Md.

18. Funeral director

L. Sueche sons

Address

Hyattsville Md

19.

(Date rec'd by registrar)

Dec 23, 1946Mrs. Jas. Severe
Deputy Social Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 22 1946 at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2:2819.. 46.. to12:2219.. 46..

and that I last saw him alive on

12:2119.. 46..

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to

Hypertensive cardiac

Due to

Vascular Disease2 years

Other conditions

Right 2nd degree

Hemiparesis

(Include pregnancy within 3 months of death)5 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

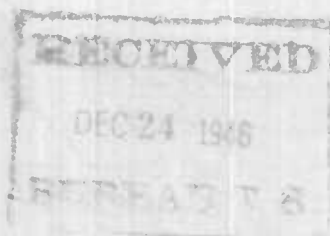
23. SIGNATURE

W. B. Meyer M.D.

M. D. or other

Address

Met. Rainier MdDate signed 12-15-46



1-25-

2-2450

1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2390

1. PLACE OF DEATH:

County PRINCE GEORGE'SCity or town LAUREL - MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 9th Street

How long in hospital or institution?

3. (a) FULL NAME

Henry William

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGE'SCity or town LAUREL -
(If outside city or town limits, write RURAL and give nearest town)Street No. 115 9th St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

CHANEY

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Feb. 19, 1946

8. AGE:

Years

Months

Days

If less than one day

109

hrs.

min.

9. Birthplace LAUREL - PR. Geo's - MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec 29

1946

M. Brashears

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28th 1946, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/26 1946, to 12/28 1946and that I last saw him alive on December 28th 1946Immediate cause of death Bronchopneumonia

DURATION

2 daysDue to Nocardia asteroides, acuteCatalase3 days

Due to

Other conditions bronchial asthma3 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Brashears, M.D.

M. D. or other

Address 305 PR. Geo. ST. Date signed 12/28/46LAUREL - MD.

BOARD OF COMMISSIONERS OF THE DISTRICT OF COLUMBIA

BOARD OF TRADEMARKS

OFFICE OF THE SECRETARY

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ANTHONY L. LORER

NO CONTENTS

RECEIVED

JAN 3 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

12288

FILM No. I 08 DEC 26 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... *St. Georges*

City or town... *St. Georges*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County...

City or town... *St. Georges*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *3601 - Eastern Ave.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Beale C. Christopher

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *married*

6. (b) Name of husband or wife *Edelle Christopher*

7. Birth date of deceased (mo., day, yr.) *Nov. 14, 1899* 8. (c) If alive, give age years

8. AGE: Years *47* Months *46* Days *1* If less than one day hrs. min.

9. Birthplace... *Pa.*
(Town, county, and state)

10. Usual occupation... *Business - Civil*

11. Industry or business *D.C. Govt*

12. Name... *John W. Christopher*

13. Birthplace *Pa.*

14. Maiden name *Margaret Dunaway*

15. Birthplace *Pa.*

16. Informant *Mrs. Edelle Christopher*

Address *3601 - Eastern Ave*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *12/18/46*

Cemetery or crematorium *Legation Cemetery*

Location *Stowards Co. Pa.*

18. Funeral director *Wm. Lee's Son & Co.*

Address *300 - 4th NE Wash D.C.*

19. *12/16* *46* *Amenda Deuney*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *12-16-* 19 *46* at *10:15 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 1946* to *12-16-* 19 *46* and that I last saw him alive on *12-16-* 19 *46*

Immediate cause of death *acute vascular failure* DURATION *5 hours*

Due to *Post operation - gastric resection for ulcer* 6 months

Due to *malignant changes*

Other conditions *steratoria* 6 months

(Include pregnancy within 3 months of death)

Major findings of operations *ulcer of stomach - post wall & dilation* Date of op. *Sept 2, 1946*

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *A. J. North* M. D. or other
Address *1433 - Monroe St* Date signed *12/16/46*

STATE OF TEXAS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

DEC 20 1946

BURFA 3

1-55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-P

CERTIFICATE OF DEATH

12289

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 mos., 6 days
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution? 4 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 929 O. Street, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

COBLE, LEVI

3. (b) Social Security Number

358-07-0473

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Separated
 6.(b) Name of husband or wife Bueford Coble
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) October 7, 1890
 8. AGE: Years 56 Months 2 Days 13 If less than one day..... hrs. min.
 9. Birthplace Roanna County, North Carolina
 (Town, county, and state)
 10. Usual occupation Bus Boy
 11. Industry or business Hot Shoppe
 12. Name Levi Coble
 13. Birthplace Roanna Co., North Carolina
 14. Maiden name Emma Warfield
 15. Birthplace Roanna Co., North Carolina

16. Informant Deceased
 Address.....
 17. renewal Date thereof Dec. 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....
 Location Washington, D.C.
 19. Funeral director Malvan & Schrey Inc.
 Address 424 - R St NW
 19. Dec. 21 1946 Rowland S. Philip Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec. 20, 1946 at 3:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/13, 1946 to 12/20, 1946
 and that I last saw him alive on 12/20, 1946
 Immediate cause of death.....
pulm. Interconosis DURATION 5 mos.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE Daniel Leo Finucane M.D.
 M. D. or other
 Address Glenn Dale, Md. Date signed 12/20/46

RECEIVED
DEC 31 1946
BUREAU 76

2-25-

2-2430- 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 570

CERTIFICATE OF DEATH

Reg. Dist. No.

12290

2451

1. PLACE OF DEATH

County Prince George
 City or town Cottage City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Prince George
 City or town Cottage City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3802 - 37th. ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Albert Cole

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Emmie Mary Cole

7. Birth date of deceased (mo., day, yr.)

March - 15 - 1875

6. (c) If alive, give age

✓ years

8. AGE:

Years

Months

Days

If less than one day

71915

hrs.

min.

9. Birthplace

Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation

fireman and oiler

11. Industry or business

Fleishman Yeast Company

FATHER

12. Name

Eyra Cole

13. Birthplace

New York State

MOTHER

14. Maiden name

Martha Mahoney

15. Birthplace

Farginer Co., Va.

16. Informant

Catherine Virginia Weaver

Address

3802 - 37th. ave., Cottage City, Md.

17. Burial

Burial
(Burial, cremation, or removal: Which?)

Date thereof

Jan 2, 1947
(month) (day) (year)

Cemetery or crematory

Monocacy Cemetery

Location

Beallsville Maryland

18. Funeral director

F. Grech's Sons

Address

Hyattsville Md.

19.

Jan 2, 1947
(Date rec'd by registrar)Mrs. J. J. Severe
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec - 30 1946 at 11:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1939 to Dec - 30 - 1946
and that I last saw him alive on Dec - 29 - 1946

Immediate cause of death

Inanition

DURATION

5 mo

Due to

Carcinoma of testis glandsMay - 1946

Due to

gastric ulcer - operat1939

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Miller M.D.

M. D. or other

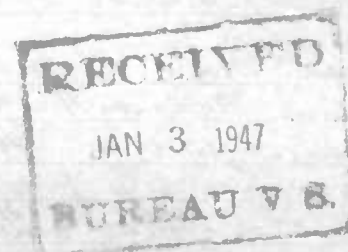
Address

Gaithersburg, Md.

Date signed

12/30/46

for undertaken



1-25

2-245-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

12291 2391
Reg. Dist. No.

1. PLACE OF DEATH:

County... Prince Georges
City or town... Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
408 Montgomery St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Prince Georges
City or town... Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No... 408 Montgomery St
(If rural, give LOCATION)
2.(a) if veteran, name war

3. (a) FULL NAME

Susan Elizabeth Bruce Grider

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Robert Sumner Grider

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) April 18, 1959

8. AGE: Years 87 Months 7 Days 2 It less than one day hrs. min.

8. Birthplace Crawford Co. Indiana (Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business Own home

12. Name Wilford Bruce

13. Birthplace Crawford Co. Indiana

14. Maiden name Sarah McManis

15. Birthplace Crawford Co. Indiana

16. Informant Mrs. Ruth Wilford Bruce

Address 408 Montgomery St Laurel Md

17. Burial Date thereof Dec 23 '46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cave Hill Cemetery

Location Louisville Kentucky

18. Funeral director Lloyd Kaiser Inc.

Address 381 Main St, Laurel

19. 12-21-46 Date rec'd by registrar

Corr E. Wachter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 1946 to Dec 20 1946 and that I last saw her alive on Dec 20 1946

Immediate cause of death Acute myocarditis DURATION 1 day

Due to

Due to

Other conditions Bronchitis 1 mo

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

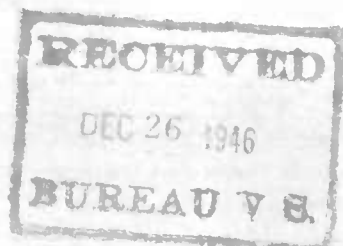
23. SIGNATURE Robert D. McManis M.D.

Address 408 Main St Laurel Md Date signed 12/20/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25-

2-2370 ————— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 12292 2310

1. PLACE OF DEATH:

County Prince George's

City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

3830-37th Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3830-37th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Leo Mathew Devlin

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary M. Devlin

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 10, 1879

8. AGE: Years 67 Months Days If less than one day hrs. min.

9. Birthplace Albany N. Y.
(Town, county, and state)

10. Usual occupation Pressman

11. Industry or business Retired

12. Name John Devlin

13. Birthplace Albany N. Y.

14. Maiden name Mary Hart

15. Birthplace Albany N. Y.

16. Informant John M. Devlin

Address 2714 - Monroe Street NW DC

17. (Burial, cremation, or removal, Which?) Date thereof Dec 11, 1946 (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location

18. Funeral director Francis J. Collier

Address 3821-14th St. NW

19. 12/18 1946 Amanda Downey
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1946, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

DURATION

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner

23. SIGNATURE Date signed 12/18/46

Address Foresthill Rd Date signed 12/18/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 21 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1372)

CERTIFICATE OF DEATH

12293

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County... Prince George's

City or town... Glen Dale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Glen Dale Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Glen Dale
(If outside city or town limits, write RURAL and give nearest town)Street No... Glen Dale Sanatorium
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Linnie M. Douglas

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Charles Douglas

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

February 14, 1893

8. AGE:

Years

Months

Days

If less than one day

53

9.

27

hrs.

min.

9. Birthplace

Machias Port Maine
(Town, county, and state)

10. Usual occupation

Hospital attendant

11. Industry or business

Glen Dale Sanatorium

12. Name

FATHER

William Dabbin

13. Birthplace

MOTHER

Maine

14. Maiden name

Laura Thompson

15. Birthplace

P.oint of Maine, Maine

16. Informant

daughter, Jeanette Douglas

Address

3145 Mt. Pleasant St. N. W. D.C.

17. Removal

(Burial, cremation, or removal. Which?)

Removal

Date thereof

Dec 12 1946
(month) (day) (year)

Cemetery or crematory

Bucks Harbor

Location

Maine

18. Funeral director

W. W. Chambers Co

Address

Washington, D.C.

19.

(Date rec'd by registrar)

Dec 11, 1946 Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 11, 1946 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on

Immediate cause of death

Acute congestive heart failure
Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

Forester W. W. Chambers
Date signed 12-11-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 19 1946
BUREAU V E.

2-25

2-2430 ——— 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

CERTIFICATE OF DEATH

12294

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs., 9 mos., 20 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 4 yrs., 9 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1101 16th St., N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

WAYLAND ENGLISH

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 21, 1875
 6. (c) If alive, give age _____ years

8. AGE: Years 71 Months 9 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Henderson, Kentucky
 (Town, county, and state)

10. Usual occupation Solicitor11. Industry or business Photography12. Name Francis M. English13. Birthplace Kentucky14. Maiden name Lollie Anna English15. Birthplace Kentucky16. Informant Deceased

Address _____

17. Burial Date thereof Dec. 28, 1946
 (Burial, cremation, or removal: Which?) (month) (day) (year)

Cemetery or crematory Columbia GardensLocation ARLINGTON, VIRGINIA18. Funeral director The S.H. Hines CoAddress 2901 14th St N.W. Washington, D. C.

19. Dec. 26, 46 Lowland Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 26, 46 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 5, 1942 to DEC. 26, 1946 and that I last saw him alive on DEC. 26, 1946

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 4 yrs 7 mos

Due to _____

Due to _____

Other conditions Complication: G.U. TUBERCULOSIS
 (Include pregnancy within 3 months of death) 4 mos.

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

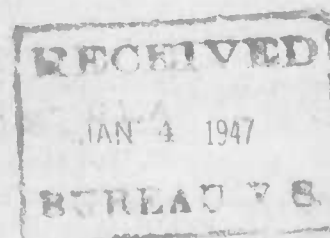
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane MD M. D. or other _____Address Glenn Dale, Md Date signed 12/26/46



2-25

2—2430 ————— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

12295

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: PRINCE GEORGES

County.....

City or town..... BERWYN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 YEARS

Hospital, institution, or street address where death occurred:

4713 BERWYN ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County..... Prince Georges

City or town..... BERWYN, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 4713 BERWYN ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

ARTHUR OCTAVE ETIENNE

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

White

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife.....

ETIENNE

8.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) APRIL 24, 1870

8. AGE: Years Months Days If less than one day

76

7

10

hrs. min.

9. Birthplace..... MONTREAL, CANADA

(Town, county and state)

10. Usual occupation.....

Physician

11. Industry or business.....

12. Name..... ARTHUR OCTAVE ETIENNE.

13. Birthplace..... MONTREAL, CANADA

14. Maiden name..... OLIVE DORION

15. Birthplace..... MONTREAL, CANADA

16. Informant..... MARTHA WOLCOTT ETIENNE (wife)

Address..... BERWYN, Md.:-

17. Burial (Burial, cremation, or removal, which?) Date thereof Dec 16, 1946

(month) (day) (year)

Cemetery or crematory..... Fort Lincoln

Location..... Washington D.C.

18. Funeral director.....

Address..... Hyattsville Md.

19. Dec. 15 1946 John H. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 December 46 4 15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 19... 19... 19...

and that I last saw him alive on 13 December 19... 46

Immediate cause of death.....

CORONARY THROMBOSIS

DURATION

1/2 hr.

Due to.....

Arteriosclerosis

15 yr

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature.....

Address.....

Date signed.....

19 DEC 1946

RECEIVED

DEC 17 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

12296

Reg. Diat. No. 2310

1. PLACE OF DEATH:

County Pr. George
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 1/2 hrs.
 Hospital, institution, or street address where death occurred
 How long in hospital or institution? 8 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County
 City or town D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1702 Sales St. N.E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Ferber

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

4. Sex m 5. Color or race 6. (a) Single, married, widowed, or divorced
 6. (b) Name of husband or wife Mary Marie Ferber

7. Birth date of deceased (mo., day, yr.) June 8, 1898 6. (c) If alive, give age years

8. AGE: Years 48 Months Days If less than one day
 hrs. min.

9. Birthplace D.C.
 (Town, county, and state)

10. Usual occupation Telephone tester

11. Industry or business

12. Name John Ferber13. Birthplace D.C.14. Maiden name Ida Gordon15. Birthplace D.C.

16. Informant

Address

17. Burial Date thereof 11/2/47

(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Cedar HillLocation Suitland, Md.18. Funeral director J. W. Lee's Sons CoAddress 360 - 4 - St. N.E.19. 1/1 47 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31- 19 46, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-30 19 46, to 12-31 19 46and that I last saw him alive on 12-30 19 46Immediate cause of death Cerebral Hemorrhage DURATIONShunt & colon with Scurvy 12 hoursDue to Antennitis? PDue to Chronic Bleeding POther conditions Fatty Degeneration P7 Lvs P

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W.B. Moyers M.D.Address Suit. Rainier Md. Date signed 12-31-46

RECEIVED
JAN 3 1947
BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

CERTIFICATE OF DEATH

12297

Reg. Dist. No. 2455

1. PLACE OF DEATH:

County Prince GeorgeCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4213 - Rainier Ave Mt Rainier

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 4213 - Rainier Ave.
(If rural, give LOCATION)2.(a) If veteran, name war World War II

3. (a) FULL NAME

THOMAS B. FESMIRE.

3. (b) Social Security Number

080-01-1702

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Aug. 6th 1900

8. AGE:

Years

Months

Days

If less than one day

46

..... hrs.

..... min.

8. Birthplace

Philadelphia Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Thos. M. Fesmire

13. Birthplace

Pa.

MOTHER

14. Maiden name

Martha V. Lunny

15. Birthplace

Pa.

16. Informant

Martha V. Lunny

Address

4213 - Rainier Ave Mt. Rainier Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/14/1946
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington Va.

18. Funeral director

Wm. J. Malley

Address

3200 - D.P. Ave. Mt. Rainier Md.

19. Rec'd

(Date rec'd by registrar)

12/1646JanSever

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946, at 8²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 9, 1944, to Dec. 12, 1946and that I last saw him alive on Dec. 11, 1946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

34 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

F. A. Connor M.D.

M. D. or other

Address

2026 - 16th St. N.W.

Date signed

12/12/46Washington, D.C.

RECEIVED
DEC 17 1946
BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

12298



Reg. Dist. No. 2431

1. PLACE OF DEATH:

County Prince Georges
City or town Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 8 mos., 9 days.
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 8 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5029 Sheriff Road, N. E.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

JAMES FINGER

3. (b) Social Security Number

218-09-0266

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Separated

6. (b) Name of husband or wife Margaret Finger
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August, 31, 1903
8. AGE: Years 43 Months 3 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Lincoln County, North Carolina
(Town, county, and state)

10. Usual occupation Radio Tech.

11. Industry or business _____

FATHER 12. Name Burton Finger
13. Birthplace North Carolina
MOTHER 14. Maiden name Julia Carpenter
15. Birthplace North Carolina

16. Informant Deceased

Address _____
17. Removal Date thereof Dec. 24, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory _____
Location to Washington, D. C.

18. Funeral director Harry S. Washington & Sons
Address 467 7th St. NW

19. Dec. 23, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1946 at 8:42 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APR. 13, 1945 to DEC. 23, 1946
and that I last saw him alive on DEC. 23, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 1 yr. 9 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other _____

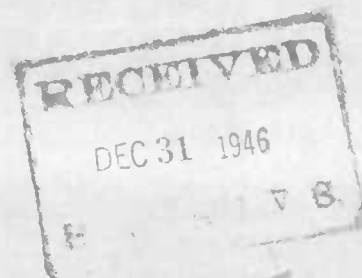
Address Glenn Dale Md. Date signed 12/23/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-25

2-2430-2-10

CERTIFICATE OF DEATH (61)

COMMONWEALTH OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICSFile No. 12299

Registered No.

(If death occurred in a
Hospital or Institution
give its NAME instead
of street and number.)

1. PLACE OF DEATH

County of PRINCE GEORGE'SRegistration
District No. 2321

Township of

or
Borough of NAYLOR
orPrimary Registration
District No.

City of (No. St. Ward)

2. FULL NAME MARY ELIZABETH FLEET

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

COLORED5. SINGLE, MARRIED, WIDOWED
OR DIVORCED (write the word)WIDOWED5a. If married, widowed, or ~~divorced~~
(or) WIFE of ROBERT LANDER FLEET6. DATE OF BIRTH (month, day, and year) OCT. 21, 1898

7. AGE

Years

Months

Days

IF LESS than
1 day, hrs.
or min.4824

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or
-
- particular kind of work.
-
- (b) General nature of industry,
-
- business, or establishment in
-
- which employed (or employer).
-
- (c) Name of employer

HOUSE WIFE
(RETIRED)9. BIRTHPLACE (city or town) NOTTINGHAM
(State or country) PR. GEORGE'S, MD.10. NAME OF FATHER Osborne L. Ford11. BIRTHPLACE OF FATHER (city or town) Nottingham
(State or country) P. G. Co. Md.

MAIDEN

12. NAME OF MOTHER Grace Lyson13. BIRTHPLACE OF MOTHER (city or town) Nottingham
(State or country) P. G. Co. Md.14. Informant MRS. REBECCA LEE(Address) NAYLOR, MD.15. Filed Dec 27, 1946 A. R. B. Smith
REGISTRAR

11-3184

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

DECEMBER 251946

(Month)

(Day)

(Year)

17.

I HEREBY CERTIFY, That I attended deceased from,

JUNE1946DECEMBER 22, 1946that I last saw him alive on DECEMBER 22, 1946and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

CARDIORENAL VASCULAR DISEASE
ESSENTIAL HYPERTENSION
VASCULAR ACCIDENT(duration) 6 yrs. mos. ds.CONTRIBUTORY DIABETES MELLITUS
(SECONDARY)

(duration) yrs. mos. ds.

18. Where was disease contracted
If not at place of death?Did an operation precede death? NO Date ofWas there an autopsy? NO

What test confirmed diagnosis?

(Signed) Alfred P. Lapin, M. D.
Dec 25, 1946 (Address) AQUASCO, MD.*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL. (See reverse side for additional space.)19. PLACE OF BURIAL, CREMATION OR
REMOVAL Prince Georges, George

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

F. B. Johnson Cannapolis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in full terms, so that it may be properly classified. Exact location of death should be given. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (h) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (h) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever write *None*.

Statement of cause of death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of

the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup") *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitia lnephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septichaemia" "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory,"

Space for additional information by physician

DEC 28 1946

BUREAU V 6

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1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12300

Reg. Dist. No.

2370

1. PLACE OF DEATH:

County BaldwinCity or town Baldwin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State MD County BaldwinCity or town Baldwin
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alice Ann Goddard

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 18608. AGE: 86 Years Months Days If less than one day _____ hrs. _____ min.9. Birthplace Baldwin Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business _____

12. Name Constantine. She was13. Birthplace Day or phase from14. Maiden name Ther. Goddard15. Birthplace Day 1. Ruzi16. Informant Mrs Louise BrajerAddress Hughesville, Md17. Burial (Burial, cremation, or removal) Which Date thereof Dec 10 1946
(month) (day) (year)Cemetery or crematory St Pauls CemeteryLocation Baldwin Md18. Funeral director Ritchie, 1340Address 1340 N. Charles St19. Dec 8 46 (Date rec'd by registrar) 20. Mrs. Mary Blake Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8th 1946 at 11 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 6 1946 to December 8 1946and that I last saw her alive on December 8th 1946

Immediate cause of death

Pulmonary Edema DURATION 24 hoursDue to ArterioscleroticCardiovascular Disease

Due to _____

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis C. Garcia MD

M. D. or other

Address Hughesville, Md Date signed 12-8-46

RECEIVED

DEC 10 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12301

Reg. Dist. No. 2450

1. PLACE OF DEATH:

County Prince George
City or town Riversdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Riversdale 5602-54th Ave.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Riversdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5602-54th Ave.
(If rural, give LOCATION)

2(a) If veteran, name war None

3. (a) FULL NAME

Harry Elwood Gray

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Helen Shepard Gray
6. (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1905

8. AGE: Years 41 Months 1 Days 15 If less than one day hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Research Statistician

11. Industry or business Potomac Elec. Power Co

12. Name James H. Gray, Sr

13. Birthplace Laurel, Md.

14. Maiden name Maudie Elwood

15. Birthplace Washington, D.C.

16. Informant James H. Gray, Sr

Address 5602-54th Ave Riversdale Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 17, 1946
(month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Colma Manor Md

18. Funeral director J. Joseph Sons

Address Hyattsville Md

19. Dec 16 1946 James Selby Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Dec 15 1946
and that I last saw him alive on Dec 14 1946

Immediate cause of death Arteriosclerotic
changes
DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. G. Hannon M. D. or other

Address Hyattsville Md Date signed 12/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1946

BUREAU 13

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157-2

12302

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince George
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
 How long in hospital or institution? 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Hoass Carla Jean

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Dec. 17, 1946

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Chesley, Prince George, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name

Carl Hoass

13. Birthplace

Md.

MOTHER

14. Maiden name

Emily Ysilton

15. Birthplace

Md.

16. Informant

Carl Hoass

Address

8419 Balti. Ave Berwyn Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

12/19/46
(month) (day) (year)

Cemetery or crematory

Greensboro

Location

Greensboro Md.

18. Funeral director

Raymond B. Rawlings

Address

Greensboro, Md.

19.

(Date rec'd by registrar)

12/19

19

46Amanda Douney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 18, 1946, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DURATION

Pulmonary edema
Due to
Congenital defect inter. ventricular
septum
Due to

6 hrs.
From
birth

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Francis Varen M.D.

M. D. or other

Address 1746 - 1st St. N.W. Date signed 12/18/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1946

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

12303

Reg. Diat. No. 2300

1. PLACE OF DEATH:

County Berwyn MdCity or town Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BerwynCity or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)Street No. 8402 49th St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Anna Hall

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) 1868

8. AGE:

Years 78Months 9Days 28

If less than one day

hrs. _____

min. _____

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 19 46 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2 19 46 to Dec 2 19 46and that I last saw him Dec 2 19 46 alive on

Immediate cause of death

Chronic Endocarditis

DURATION

2 yrs +

Due to

Atherosclerosis2 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. O. ETIENNE, M. D.

M. D. or other

Address

BERWYN MD

Date signed

12/4/46

RECEIVED
DEC 7 1946
BUREAU VS

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

12304

CERTIFICATE OF DEATH

Reg. Dist. No. 2430

1. PLACE OF DEATH:

County PRINCE GEORGECity or town HILLMEADE
(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County PRINCE GEORGECity or town HILLMEADE
(if outside city or town limits, write RURAL and give nearest town)Street No. DAISEY ROAD
(If rural, give LOCATION)2.(a) If veteran, name war SPANISH AMERICAN

3. (a) FULL NAME

WILLIAM L. HAMMERLY

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED8. (b) Name of husband or wife MARY J.JULY 17, 1973 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) 18938. AGE: Years 73 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace LEESBURG, VIRGINIA
(Town, county, and state)10. Usual occupation CHICKEN FARMER

11. Industry or business

12. Name ARCHIE HAMMERLY13. Birthplace LEESBURG, VA.14. Maiden name JULIE A. BRENNER15. Birthplace ALEXANDRIA, VA.16. Informant MRS MARY J. HAMMERLYAddress HILLMEADE, MD.17. BURIAL Date thereof DEC. 20 1976
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ashington Mth. ashington Md.Location ashington, Va18. Funeral director W. W. Chambers Co.Address 5801 Cleveland Ave. Bowie, Md.19. 12/17 19 46 Amanda Deane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-17 19 46 at 730 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 46 to Dec. 17 19 46and that I last saw him alive on Dec. 17 19 46Immediate cause of death Acute Congestive Heart FailureDue to Chronic Myocarditis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Roger S. Williams, M.D.
M. D. or other _____Address 35 New York Ave. NW. Date signed 12/17/46
Washington D.C.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 23 1946

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (752)

CERTIFICATE OF DEATH

Reg. Dist. No. 2420

12305

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Eugene Howard

3. (b) Social Security Number

4. Sex.....
5. Color or race.....
6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....
8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Removal..... Date thereof.....
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Dec. 27 1946 Carrin F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Dec. 27 1946 and that I last saw him alive on Dec. 27 1946

Immediate cause of death..... DURATION

Fluid Aspiration.....

Vomiting.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
DEC 31 1946
BUREAU 8

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12306 2300

1. PLACE OF DEATH:

County Prince Georges
City or town Lakeland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? over 40 yrs.
Hospital, institution, or street address where death occurred:
4408 Lakeland Road
How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Lakeland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4408 Lakeland Road
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Hariett Hughes

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Samuel Hughes (dec)
5.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)

10. Usual occupation Lived with daughter

11. Industry or business unemployed

12. Name Joseph Butler

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Beatrice Thomas (daughter)
Address 4408 Lakeland Rd. Lakeland, Md.

17. Burial Burial Date thereof Dec. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery
Location Bladensburg Md.

18. Funeral director Henry S. Washington & Sons
Address 467 N. St. N.W. Wash. D.C.

19. Dec 17th 1946 John D. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-26 1946 to 12-14 1946
and that I last saw him/her alive on 12-11 1946

Immediate cause of death Myocarditis
acute

DURATION

months

Due to Weak heart muscle

Due to Acute Stomatitis

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William W. Spiller M.D.
M. D. or other _____

Address Brantwood, Md. Date signed 12-14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
DEC 19 1946
BUREAU V.E.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

12307

1950

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George'sCity or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 month

3. (a) FULL NAME

Esra Earnest Jager

3. (b) Social Security Number

4. Sex M 5. Color of face W 6. (a) Single, married, widowed, or divorced married8. (b) Name of husband or wife Mary A. Jager7. Birth date of deceased (mo., day, yr.) Nov 2, 18848. (c) If alive, give age 58 years8. AGE: Years 63 Months 1 Days 23 If less than one day
..... hrs. min.9. Birthplace Scaggsville Md
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Martin Jager13. Birthplace Germany

14. Maiden name

15. Birthplace

18. Informant Esra JagerAddress Scaggsville, Md17. Burial Date thereof Dec. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St PaulsLocation Laurel Md18. Funeral director Walter H. HaysAddress Laurel MdFrank Shipley 12/26/46

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HowardCity or town Laurel (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. Scaggsville
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946, at 5:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death Myocardial Infarction

DURATION

1 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE J M Warren MD

M. D. or other

Address Laurel Md Date signed 12/23/46

10021

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

ANTHONY J. BOYLE

RE: KAS-CONTENT

10/2/46

RECEIVED
JAN 2 1947
BUREAU V 8

2-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12308

Reg. Dist. No. 2450

1. PLACE OF DEATH:

County Prince George County
City or town Near Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mother Jones Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

LOTTIE HOOVER JACKMAN

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife James W. Jackman

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 7, 1877

8. AGE: Years Months Days If less than one day
69 6 23 hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Retired, Real Estate

11. Industry or business

12. Name Thomas Zell Hoover

13. Birthplace Washington, D. C.

14. Maiden name Alice Hains

15. Birthplace New York State

16. Informant Mr. Frank Hoover

Address 6807 Glenbrook Rd. Bethesda, Md.

17. Burial Date thereof 1/2/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington Virginia

18. Funeral director W. Reuben Humphrey

Address Bethesda, Maryland

19. (Date rec'd by registrar) 20. 47 Janu Severy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 46 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 29 19 46 to December 29 19 46
and that I last saw HER alive on Dec 29 19 46

Immediate cause of death

Cardiac decompensation due to mitral regurgitation

DURATION

48 hrs.

Due to.....

Due to.....

Other conditions

general debility, all of age chronic bronchitis
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm A. Shannon M.D. M. D. or other

Address 113 Carroll St NW Date signed 12-31-46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 3 1947
BUREAU V B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

12309

Reg. Dist. No. 245

1. PLACE OF DEATH:
 County Prince Georges
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:
Sacred Heart Home
 How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED
 (For newborn infants give residence of mother)
 State md. County Charles.
 City or town Bel Air
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name War _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex 3 5. Color or race W 6.(a) Single, married, widowed, or divorced W.

6.(b) Name of husband or wife Clarence Jamison
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 28 1863

8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Charles City, Md.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Washington A. Posey
 13. Birthplace md.

14. Maiden name Margareth Hammesley
 15. Birthplace md.

16. Informant Hosp. Records
 Address _____

17. Burial Date thereof Dec 6, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. Ignace
 Location Bel Air, Md.

18. Funeral director Funer. & Ryon
 Address Waldorf, Md.

19. Dec 4 1946 James Sevey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Dec. 4 1946
 and that I last saw her alive on December 3 1946

Immediate cause of death Arteriosclerotic Heart Disease DURATION 9 mos.
Congestive failure 4 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thom Hollins MD M. D. or other _____

Address 322-H N.E. Date sign DEC. 4 1946

RECEIVED
DEC 5 1946
BUREAU V.S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 12310
 Reg. Dist. No. 2420

1. PLACE OF DEATH:

County Prince George's
 City or town Chapel Baker
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
5403 - Addison Chapel Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Chapel Baker
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5403 Addison Chapel Road
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

James Thomas Jefferson

3. (b) Social Security Number

212-16-0287

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Elizabeth Jefferson
 6. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) Feb 10, 1890
 8. AGE: Years 56 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md
 (Town, county, and state)
 10. Usual occupation Janitor
 11. Industry or business School
 12. Name Atta Jefferson
 13. Birthplace Virginia
 14. Maiden name Margaret Taylor
 15. Birthplace Virginia

16. Informant Elizabeth Jefferson
 Address 5403 Addison Chapel Rd, Chapel Baker
 17. Burial Date thereof 12/1/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Vernon
 Location Baltimore Md.
 18. Funeral director Henry S. Washington & Sons
 Address 467 M St. N.W.

19. Dec 1 1946 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946 at 6:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death Acute congestive heart failure
 Due to cardio-vascular renal disease

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

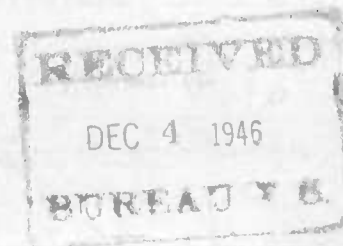
Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE James T. Taylor M. D. or other _____
 Address Frostville Md Date signed 12-1-46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

12311

Reg. Dist. No. 2421

1. PLACE OF DEATH:

County Brown
 City or town Allentown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
7112 Allentown Rd

How long in hospital or institution?

3. (a) FULL NAME

Charles Henry Johnson

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Eleanor Johnson

7. Birth date of deceased (mo., day, yr.) Oct 24, 1889 6. (c) If alive, give age 49 years

8. AGE: Years 56 Months 1 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Brown Hill, Md
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Charles Johnson13. Birthplace Maryland14. Maiden name Mary Calbert15. Birthplace Maryland16. Informant Eleanor JohnsonAddress 7112 - Allentown Road17. Burial Date thereof Dec. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oxon Hill - MdLocation Plot 14 - 184618. Funeral director John J. Dwyer & CoAddress 901 - 3rd St. S.W.19. 12-12-46 Thos B. Giffitt
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Brown
 City or town Allentown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 7112 Allentown Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946 at 8:57 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____

and that I last saw him _____ alive on _____ 19_____

Immediate cause of death _____ DURATION

Acute congestive heartfailureDue to arterioscleroticdegenerative

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Report medical examiner23. SIGNATURE Foranally M. DwyerAddress _____ Date signed 12-11-46

RECEIVED

DEC 16 1946

BUREAU W.B.

1-25

2-2470 ——— 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17-2

12312

CERTIFICATE OF DEATH

Reg. Dist. No. 2451

1. PLACE OF DEATH: Prince George
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Leeland Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 North Southway
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME
Johnson, Mrs. Clara Mae

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Leslie Jackson Johnson
(Deceased) 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1881

8. AGE: Years 65 Months 1 Days 22 If less than one day
hrs. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Henry Austin

13. Birthplace Kentucky

14. Maiden name Clemmie M. Morrison

15. Birthplace Kentucky

16. Informant Hospital Records

Address

17. Burial Date thereof 12-18-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Old Hickory Cemetery

Location Lebanon, Ky

18. Funeral director W W Chauvin Co

Address Riverdale

19. Dec 18 1946 Mrs. Joe Devere
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1946 at 9:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945 to Dec. 16, 1946
and that I last saw h. ex. alive on December 16, 1946

Immediate cause of death.....
Uremic
Due to Hypertensive cardio-renal disease
Due to.....

DURATION

10 days

2 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... M. D. or other

Address 30-0 Bridge Rd, Greenbelt, Md. Date signed 12-16-46

MARGIN RESERVED FOR BINDING

VS A-15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ADJUTANT TO THE ATTORNEY GENERAL

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

UNITED STATES

NOV 21 1946

UNITED STATES

RECEIVED

DEC 21 1946

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2-2450-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

CERTIFICATE OF DEATH

★ 12313
Reg. Dist. No. 2430

1. PLACE OF DEATH:

County Bowie Md
City or town Bowie Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Frederick Co.
City or town Bowie Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Jefferson Co. Kinsey

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Alie Kinsey

7. Birth date of deceased (mo., day, yr.) Nov 28, 1884 6. (c) If alive, give age 46 years

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Construction wood

11. Industry or business _____

12. Name Erasmus Kinsey

13. Birthplace South Carolina

14. Maiden name Mary Williams

15. Birthplace South Carolina

16. Informant J Lee Kinsey

Address Bowie Md

17. Burial Date thereof Dec 16, 1946
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Colman Manor Md.

18. Funeral director J. Gies's sons

Address Bladensburg Md.

19. 12/15 19 46 Wanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14, 1946 at 6:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Hemorrhage of stomach

Due to multiple gunshot injuries to entire body

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-13-46

Where did injury occur? Bowie P.D. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on tracks

Means of injury Shed of train Injured at work? no

deputy medical examiner

23. SIGNATURE Forester M. D. Other _____

Address Forester Md Date signed 12-14-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 23 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

12314

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince Georges
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 hrs. 55 min.Hospital, institution, or street address where death occurred:
Pr. Geo. General Hosp.How long in hospital or institution? 3 hrs. 55 min.

3. (a) FULL NAME

Knobla, male infant4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced newborn

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
3 hrs. 55 min.9. Birthplace Pr. Geo. Cheverly, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Bernard Knobla13. Birthplace Wisconsin14. Maiden name Marguerite Washn15. Birthplace Wisc Wisconsin

16. Informant

Address

17. Cremation Date thereof 12/20/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prince Georges General HospitalLocation Cheverly, Md.18. Funeral director A. J. Besley, Supt.Address same19. 12/23 19 46 Amanda Dourney
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo.City or town Renardale
(If outside city or town limits, write RURAL and give nearest town)Street No. 5632 64th ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 19 46, at 12 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-18 19 46 to 12-19 19 46and that I last saw him alive on 12-18 19 46Immediate cause of death Atelectasis - due to DURATIONCentral respiratory depressionDue to Prematurity2'-12" - 30 wks gestation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Francis Waver, M.D.Address 1746 - R St. N.W. Date signed 10/19/46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTERIAL LEADER

NO CONTENT

RECEIVED

DEC 24 1946

BUREAU V S.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37)

CERTIFICATE OF DEATH

12315

Reg. Dist. No. 2300

1. PLACE OF DEATH:

County Prince Georges

City or town Murkirk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Prince Georges

City or town Murkirk
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Anna Lomax

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Sept. 6 1921

8. AGE: Years 25 Months 3 Days 21 11 less than one day _____ hrs. _____ min.

9. Birthplace Murkirk md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name William Henry Lomax
13. Birthplace md.

MOTHER 14. Maiden name Mary Jane Brewer
15. Birthplace md.

16. Informant William Henry Lomax

Address Murkirk Md.

17. Burial Date thereof Dec. 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Queen's Chapel

Location Murkirk Md.

18. Funeral director Henry S. Washington & Sons

Address 467 N. St. N.W. Wash. D.C.

19. Dec 28th 19 46 J. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 19 46 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 41 19 46, to Dec 24 19 46, and that I last saw him alive on Dec 22 19 46.

Immediate cause of death

Dehydration

DURATION

2 ms

Due to Pulmonary TB

5 yrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

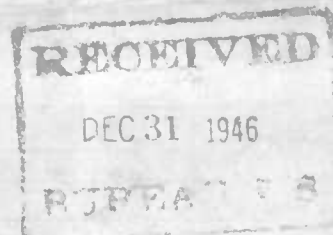
23. SIGNATURE W. S. Hudson, M.D. M. D. or other _____

Address Laurel Md. Date signed 12-24-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 12316 2310

1. PLACE OF DEATH:

County Prince Georges
 City or town Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 1/2 hours
 Hospital, institution, or street address where death occurred:
Prince Georges General Hosp
 How long in hospital or institution? 5 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 507 67th Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rose A Long

3. (b) Social Security Number

4. Sex Female 5. Color or race w 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Robert K Long

7. Birth date of deceased (mo., day, yr.) Dec 1879 8.(c) If alive, give age 71 years

8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and estate)

10. Usual occupation _____

11. Industry or business _____

12. Name B. H. Smith

13. Birthplace Virginia

14. Maiden name Gerty Garner

15. Birthplace Virginia

16. Informant Mrs Helen Roberts

Address _____

17. Removal Date thereof Dec 6 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington, D.C.

18. Funeral director Robert Mattingly

Address 131-11th St. S.E. Wash. D.C.

19. 12/6 1946 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Pulmonary edema

Toxemia

Due to Bilateral broncho-

pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Deputy Medical Examiner
[Signature] M. D. or other _____

Address Frederick Md Date signed 12-6-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF THE ARMY

HEADQUARTERS, ARMY

WASHINGTON, D. C.

100-100000

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RECEIVED
DEC 9 1946
BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (464)

CERTIFICATE OF DEATH

Reg. Dist. No. 12317 2450

1. PLACE OF DEATH:

County... PRINCE GEORGE'S

City or town... HYATTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mo.

Hospital, institution, or street address where death occurred:
SACRED HEART HOME

How long in hospital or institution? 1 yr. 3 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...

City or town... WASHINGTON
(If outside city or town limits, write RURAL and give nearest town)Street No. 3426-16TH ST. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

CATHERINE MCCHESNEY

3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife

CHARLES G.

7. Birth date of deceased (mo., day, yr.)

May 29, 1862

6. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

84

6

7

hrs.

min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Benford SAUTER

13. Birthplace

GERMANY

MOTHER

14. Maiden name

CATHERINE EISENHauer

15. Birthplace

GERMANY

16. Informant

SACRED HEART HOME

Address

HYATTSVILLE, MD

17.

(Burial, cremation, or removal. Which?)

Date thereof

12-9-46
(month) (day) (year)

Cemetery or crematory

Rock Creek Cemetery

Location

Washington, D.C.

18. Funeral director

Francis Keelins

Address

3821-14th St. N.W. Wash D.C.

19.

DEC 6 1946
(Date rec'd by registrar)

1946

James Bevel

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1946 to Dec 8 1946
and that I last saw him alive on Dec 5 1946

Immediate cause of death

Sarcoma of rectum

DURATION

1 year

Due to

Due to

Other conditions

old age

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph J. McCarthy M.D.
Address: 3001 9th St. N.W. DC 20012 Date signed: 12/19/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, COMMONWEALTH OF MASSACHUSETTS

DEATH NO. 10000

PORTLAND, MAINE

RECEIVED
DEC 9 1946
BUREAU 78

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

123182450
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4310-37th. Street
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Harland Odell Mc Elwain

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Louise T. Robinson

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

July 5, 1871

8. AGE: Years 75 Months Days If less than one day
hrs. min.

8. Birthplace Iowa
(Town, county, and state)

10. Usual occupation Repairman11. Industry or business Jewelry Business12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Louise T. Mc ElwainAddress 4310-37th. Street, Brentwood, Md.

17. Burial Date thereof Dec. 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rice Cemetery Elkhart, IndianaLocation Elkhart, Indiana18. Funeral director Wm J. GalleyAddress 3200-R.I. Ave. Mt. Rainier, Md.

19. Dec 10 1946 J. Lewis Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9th - 1946, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 8 - 1946, to December 9 - 1946
and that I last saw him alive on December 4 - 1946

Immediate cause of death Cardiovascular Renal Disease
DURATION 9 months

Due to Hypertensive Heart Disease 9 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

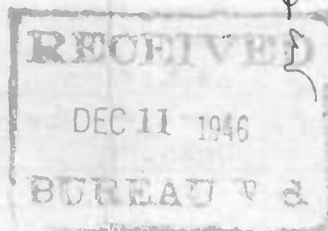
Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address Mt. Rainier, Md. Date signed 12/9/46

1946
Dr. James I. Boyd, County
Coroner, notified by me also
approve.

[Signature]



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3/5)

CERTIFICATE OF DEATH

Reg. Dist. No.

12319

2451

1. PLACE OF DEATH:

County... Prince George
 City or town... Hyattsville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Wash County... DC
 City or town... Washington DC
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 6619 - Western Ave NW
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex... female
 5. Color or race... white
 6.(a) Single, married, widowed, or divorced... widow
 6.(b) Name of husband or wife... Michael J. Mc Lurney
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... Sept 28, 1859
 8. AGE: Years... 87 Months... Days... If less than one day... hrs. min.

MEDICAL CERTIFICATION

2D. DATE OF DEATH... Dec. 25, 1946, at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1946, to Dec. 25, 1946, and that I last saw him alive on Dec. 23, 1946.

Immediate cause of death... Radio - vascular - renal disease
 DURATION... Indefinite

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

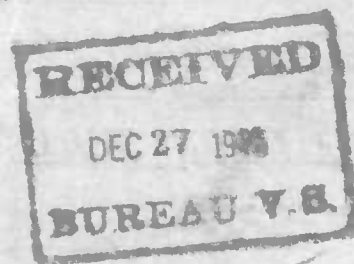
Means of injury Injured at work?

23. SIGNATURE... F. A. Connor, M.D.

Address... 2036-16th St. N.W. Date signed... 12/25/46

Washington, D.C.

9. Birthplace... Wash DC.
 (Town, county, and state)
 10. Usual occupation... at home
 11. Industry or business... Thomas Connors
 12. Name... Thomas Connors
 13. Birthplace... Ireland
 14. Maiden name... Ireland
 15. Birthplace... Ireland
 16. Informant... Joseph Koretz
 Address... Sacred Heart Home
 Burial
 Date thereof... 12/28/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Mt Olivet
 Location... Washington, D.C.
 17. Funeral director... T. F. Costello
 Address... 1722 N. Capitol St. NW
 18. Dec. 25, 1946
 (Date rec'd by registrar) Registrar



1-25

2-2450 — 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12320
2340

1. PLACE OF DEATH:

County Prince George
 City or town Piscataway, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr Geo Co
 City or town Piscataway, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (a) FULL NAME

Mrs. Georgia Frances Middleton

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Mr. Alexander Middleton
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1874

8. AGE: Years 72 Months 9 Days 3 hrs. min.

9. Birthplace Piscataway, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Underwood
 13. Birthplace Accokeek, Maryland
 MOTHER 14. Maiden name Ann Underwood Boswell
 15. Birthplace Accokeek, Maryland

16. Informant Alexander Middleton
 Address Piscataway, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 31 - 1946
 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery
 Location Piscataway, Md.

18. Funeral director Thomas F. Murray's Funeral Home
 Address 2007 Nichols Ave. S.E.

19. 12/28 46 Mrs. Middleton
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1946 at 5 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 37 to 12/26 1946
 and that I last saw him 20 alive on 12/20 1946

Immediate cause of death Caudice
decompensation

Due to C. V. D. Disease

Due to Family

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address Washington Md Date signed 12/26/46

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12321

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince George's
 City or town Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Will Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7 Hill Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

James Walter Miles

3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife James Miles

7. Birth date of deceased (mo., day, yr.) May 18, 1869 8.(c) If alive, give age _____ years

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Mc Connellsburg, Pa
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER 12. Name Charles P. Miles

13. Birthplace Maryland

14. Maiden name Sarah Johnson

15. Birthplace Maryland

16. Informant Grant P. Miles

Address Will Road, Seat Pleasant

17. Burial Date thereof 12-23-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Reformed Ch. Cemetery

Location Boonstown, Md.

18. Funeral director W. W. Chambers Co

Address Riversdale, Md.

19. 12/22 19 46 Amanda Doney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1946 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

Due to Acute congestive heart failure

Due to Cardiovascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE James P. Jones M. D. or other _____

Address Frederick, Md. Date signed 12-21-46

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

12322

1. PLACE OF DEATH

County Prince George's Registration Dist. No. 2391
 Village or City Lanham No. R.E.D. St. Ward
 (If death occurred in a hospital or institution, give its NAME instead of street and number)
 Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Alice Moore If U. S. Veteran, specify WAR
 (a) Residence: No. St. Ward.
 (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u></u>		
6. DATE OF BIRTH (month, day, and year) <u>Unknown 1863</u>		
7. AGE <u>83</u>	Years <u></u> Months <u></u> Days <u></u>	If LESS than 1 day, <u></u> hrs. or <u></u> min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u></u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>House work</u>	
	10. Data deceased last worked at this occupation (month and year) <u></u>	
11. Total time (years) spent in this occupation <u></u>		

FATHER	12. BIRTHPLACE (city or town) (State or country) <u>Maryland</u>
	13. NAME <u>Upton Moore</u>
MOTHER	14. BIRTHPLACE (city or town) (State or country) <u>Carroll, Co. Md</u>
	15. MAIDEN NAME <u>Emeline Hughes</u>
INFORMANT	16. BIRTHPLACE (city or town) (State or country) <u>Carroll Co. Md</u>
	17. INFORMANT <u>Miss Nina Moore</u> (Address) <u>Montgomery Rd Lanham Md</u>
18. BURIAL, CREMATION, OR REMOVAL Place <u>Lay Hill Land</u> Date <u>Dec. 9, 1946</u>	
19. UNDERTAKER <u>Ridgely Selby</u> (Address) <u>401 Wood Ave Lanham Md</u>	
20. FILED <u>12-9-46</u> <u>Cora E. Wachtel</u> <u>Deputy Registrar</u>	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 7, 1946
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from October 31, 1946 to December 7, 1946
 I last saw h. or alive on December 7, 1946; death is said to have occurred on the date stated above, at 9:30 P.m.
 The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Hypertensive Cardiac -
vascular disease
2 Chronic Nephritis
3 Arterio-sclerosis

Date of onset
19461945
undetermined

Other Contributory Causes of Importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:
 Accident, suicide, or homicide? Date of injury , 19
 Where did injury occur?
 (Specify city or town, county and State)
 Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify
 (Signed) Stephen M. D.
 (Address) 305 Prince Geo. St. Land Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

2-2397-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1332

CERTIFICATE OF DEATH

12323
Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Pro Geo Co.
 City or town Cherry Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Pro Geo Co
 City or town Myattsville Ind.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5307 Crutcher st
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Charles Byron Murray

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mary Alice Murray
 6. (c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) Aug 31, 1907
 8. AGE: Years 39 Months 3 Days 14 If less than one day
 hrs. min.

9. Birthplace Washington D.C.
 (Town, county, and state)

10. Usual occupation Printer

11. Industry or business Star Newspaper

12. Name Henry A. Murray

13. Birthplace Ind.

14. Maiden name Mary J. Thomas

15. Birthplace Ind.

16. Informant Mary Alice Murray

Address Myattsville Ind.

17. Burial Date thereof Dec 18, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Washington D.C.

18. Funeral director F. Busch's Sons

Address Myattsville Ind.

19. 12/18 19 46 Amanda Deuney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 46 at 8:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12/19 19 46 to 12/15 19 46

and that I last saw him alive on 12/15 19 46

Immediate cause of death uricemia

poisoning

Due to Pylonephritis bilateral

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George H. Grainger M. D. or other

Address 3217 - 38th St Date signed 12/15/46

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 20 1946

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

12324

Reg. Dist. No. 1420

1. PLACE OF DEATH:

County PRINCE GEORGE
 City or town SUITLAND MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 YRS
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County PRINCE GEORGE
 City or town SUITLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5070 SILVER HILL ROAD
 (If rural, give LOCATION)
 2.(a) If veteran, name war NONE

3. (a) FULL NAME

CLARA LILLIAN GLEASON NORTON

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED
 6.(b) Name of husband or wife IRA L. NORTON
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) JULY 27th 1888
 8. AGE: Years 58 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace HYATTSVILLE MD
 (Town, county, and state)
 10. Usual occupation NONE
 11. Industry or business NONE
 12. Name GILBERT H. GLEASON
 13. Birthplace BOSTON MASS
 14. Maiden name LILLIAN E NORTON
 15. Birthplace CEDARVILLE PA.

16. Informant Ira L. Norton
 Address 5070 SILVER HILL RD. SUITLAND MD.
 17. BURIAL Date thereof 12-10-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory WASH. NATIONAL
 Location SUITLAND MD.
 18. Funeral director W. W. Chambers Co.
 Address 517 11th St. S.E.

19. Dec. 7 19 46 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 19 46 at 10:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 19 46 to Dec 6 19 46
 and that I last saw him alive on Dec 6 19 46

Immediate cause of death Cerebral Hemorrhage
 Due to Hypertension
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Andrew Anders M. D. or other
 Address 4671 Homer ave Date signed 12/7/46

Notified coroner and approved
Andrew Anders



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 2421

1. PLACE OF DEATH:

County Prince George County
 City or town Oxen Hill
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or nrmnt address where death occurred:

6000 Brinkley Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Oxen Hill
 (If outside city or town limits, write RURAL and give nearest town)Street No. 6000 Brinkley Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DELIA O'BRIEN

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Patrick O'Brien

7. Birth date of

deceased (mo., day, yr.)

1859

6.(c) If alive, give age years

8. AGE:

Year

Month

Day

If Innn than onn day

87?

.....hrs.

.....min.

8. Birthplace

Ireland
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

unk

13. Birthplace

MOTHER

14. Maiden name

unk

15. Birthplace

16. Informant Mr. Charles F. O'Brien (son)Address 1032 North Nelson, Arlington, Va.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 23, 1946
 (month) (day) (year)

Cemetery or crematory

Holy Rood Cemetery

Location

Washington, D.C.

18. Funeral director

Address

317 Pennsylvania Ave., S.E.19. 12-21-46
 (Date rec'd by registrar)Thos. D. English
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 19 46, at 8:12 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 - 1946, to Dec 21 1946and that I last saw him alive on Dec 21 1946Immediate cause of death Acute pulmonaryEdema

DURATION

Due to

Due to

Other condition

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

RECEIVED
DEC 26 1946
BUREAU

1-25

2-2420 ————— 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

12326

CERTIFICATE OF DEATH

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County Prince Georges County
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month and 25 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 month and 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State - County -
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 309 1/2 Va. Ave. S.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

CHARLES POE.

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife -

7. Birth date of deceased (mo., day, yr.) April 10, 1911 6.(c) If alive, give age - years

8. AGE: Years Months Days If less than one day
35 35 2 10 hrs. min.

9. Birthplace Washington, D.C.
 (Town, county, and state)

10. Usual occupation Labor Foreman

11. Industry or business -

12. Name Virgil Poe

13. Birthplace North Carolina

14. Maiden name Maggie Bailey

15. Birthplace Virginia

16. Informant Deceased

Address

17. Removal Date thereof Dec. 20, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location to Washington, D.C.

18. Funeral director Home & Carter

Address 600 2nd St. S.W.

19. Dec. 20, 1946 Kouland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20th 1946 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24th 1946 to Dec 20 1946
 and that I last saw him alive on Dec 19th 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 5 mos

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

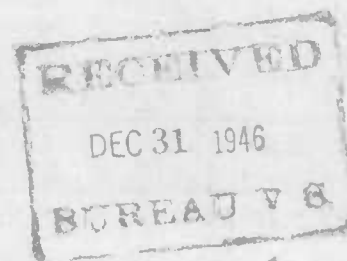
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD M.D. or other

Address Glenn Dale, Md. Date signed 12/20/46



2-25

2-2430-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12327

Reg. Diat. No.

230

1. PLACE OF DEATH:

PRINCE GEORGE

DANIELS PARK

(If inside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ALICE F. RHINE

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Richard H. Rhine

7. Birth date of

deceased (mo., day, yr.)

Dec - 19 - 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

69

hrs. min.

9. Birthplace

Bermingham, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Morris Ward

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary

15. Birthplace

Md.

16. Informant

Eldred H. Rhine

Address

6915 Timrod Ave. Sea Pines, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Burial

12-16-46

18. Funeral director

St. John's Episcopal Cemetery

Location

Beltsville - Md.

19. Funeral director

Mr. Mr. Chambers Co.

Address

5801 Chelmsford Ave. Beltsville, Md.

19.

(Date rec'd by registrar)

Dec 15 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

PRINCE GEORGES

City or town

DANIELS PARK

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4910 ERIE STREET

(If rural, give LOCATION)

2. (d) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec - 13

1946

at 8:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 5

1946

to Dec 13

1946

and that I last saw her alive on

12-13

1946

Immediate cause of death

Arteriosclerotic heart disease with pulmonary edema

DURATION

Several years

Due to

Due to

Other conditions

Hypertrophic arthritis advanced

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dayton D. Watkins MD

M. D. or other

Address

5304 Annapolis

Date signed 12-13-46

Road Hyattsville Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1946

BUREAU 6

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

12328

Reg. Dist. No. 2340

1. PLACE OF DEATH:

County... Prince Georges
City or town... Decatur
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Prince George
City or town... Decatur
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2(a) If veteran, name war...

3. (a) FULL NAME

James Elmer Richards

3. (b) Social Security Number

4. Sex... male
5. Color or race... W.
6. (a) Single, married, widowed, or divorced... married
6. (b) Name of husband or wife... Vannie Richards
6. (c) If alive, give age... 64 years
7. Birth date of deceased (mo., day, yr.)... Oct 25, 1878
8. AGE: Years 68 Months 2 Days 0 If less than one day... hrs. ... min.

9. Birthplace... Maryland
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business

MOTHER, FATHER
12. Name... Joseph Richards
13. Birthplace... Maryland
14. Maiden name... Mary Goldsmith
15. Birthplace... Maryland

16. Informant... Margaret Richards
Address... Decatur, Md.

17. Burial... Date thereof... 12-27-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Paul's
Location... Decatur, Md.

18. Funeral director... H. H. Hays
Address... Upper Marlboro, Md.

19. 12/26 1946... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 25 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19... and that I last saw him... alive on... 19...

Immediate cause of death... Congestive heart failure
Due to... Coronary arterial disease
Due to...

Other conditions...
(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?
Signature... Deputy Medical Examiner
M. D. or other...
Address... Freshville, Md. Date signed... 12-25-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 623

CERTIFICATE OF DEATH

12329

★ Reg. Dist. No. 245 0

1. PLACE OF DEATH:

County Pro Geo co
 City or town Hyattsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Pro Geo co
 City or town Hyattsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5508 - 43 Place
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lora H. Riley

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Filmore Riley
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 18 - 1855
 8. AGE: Years 91 Months - Days - If less than one day _____ hrs. _____ min.

9. Birthplace Pa (Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Filmore Riley
 13. Birthplace West Pa
 14. Maiden name Mary Ray
 15. Birthplace

16. Informant Mrs Mary Langford
 Address College Park Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 10, 1946
 (month) (day) (year)
 Cemetery or crematory Lorraine
 Location Baltimore Md

18. Funeral director F Gasch's sons
 Address Hyattsville Md.

19. Dec 10 1946 James Sevey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Dec 8 1946

and that I last saw him alive on 12-8 1946Immediate cause of death Senility

DURATION

3 mo!

Duo to

Duo to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

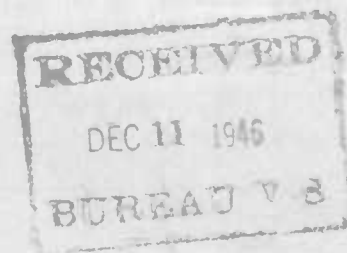
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Sevey M.D. M. D. or otherAddress Wt. Raining Md Date signed 12-9-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98

CERTIFICATE OF DEATH

12330
Reg. Dist. No. 2451

1. PLACE OF DEATH:

County Prince George
City or town Near Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

WINDEN AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

AMANDA RITTNER

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Francis

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Feb. 5, 1956

8. AGE:

90

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec.

(Date rec'd by registrar)

27 19 46 Mr. Jan Severe
Deputy Social Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 46 at 12:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24 19 44 to Dec. 26 19 46

and that I last saw him alive on December 26 19 46

Immediate cause of death

Circulatory collapse

DURATION

12 hrs.

Due to

Arteriosclerosis and Hypertension

years

Due to

Senility

"

Other conditions

Hyper trophic Arthritis

4 yrs. +

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Wallace H. Mook M.D.
805 Carroll Avenue M. D. or other

Address Takoma Park, Md. Date signed 12-27-46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1946

BUREAU 78

1-25

2-2450- 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12331

Reg. Dist. No.

2450

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 17 hrs.
 Hospital, institution, or street address where death occurred:
Edmonston Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Prince Georges
 City or town..... Berwyn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Edmonston Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gerald Roland Salisbury

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... 10/10/46
 8. AGE: Years..... Months..... Days..... If less than one day.....
1 24 hre. min.

9. Birthplace..... Genveva, New York
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Jesse Otis Salisbury
 13. Birthplace..... W. Va.

MOTHER 14. Maiden name..... Gladys Rose Wagner
 15. Birthplace..... Baltimore, Md.

16. Informant..... Mrs. Gladys R. Salisbury
 Address..... Berwyn, Md.

17. Burial Date thereof..... The 5. 1946
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Evergreen
 Location..... Bladenburg Md

18. Funeral director..... F. Gaeche's sons
 Address..... Hyattsville Md.

19. Spec 5 46 James Sever
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12/4/46..... 19..... at..... 8:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... asphyxia..... DURATION.....Due to..... Overlaying of Mother.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

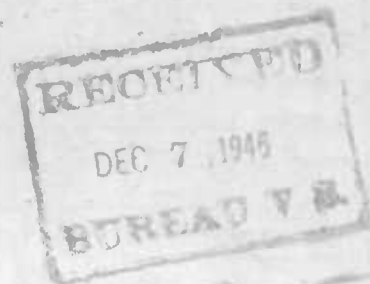
Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 12/4/46Where did injury occur?..... Berwyn..... P.G...... Md.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... homeMeans of injury..... Overlaying of Mother..... at work?23. SIGNATURE..... James S. O. Boyd..... M. D. or otherAddress..... Frederick Md Date signed..... 12-4-46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12332

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County..... Prince Georges
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 22 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 153 Kentucky Ave., S. E.
(If rural, give LOCATION)
2. (a) If veteran, name war Army, 1921 to 1924

3. (a) FULL NAME

CLIFFOR R SCOTT

3. (b) Social Security Number

579-14-7845

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Dorothy L. Scott

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1904

8. AGE: Years 41 Months 11 Days 14 If less than one day hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Cab Driver

11. Industry or business

12. Name Harry F. Scott

13. Birthplace Des Moines, Iowa

14. Maiden name Virginia S. Winfree

15. Birthplace Richmond, Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation or removal? Which?) Date thereof Dec. 8, 1946
(month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Wash. D.C.

18. Funeral director Wm. Lee's Sons Co

Address 300 4th N.E. Wash. D.C.

19. Dec. 8, 1946 Rowland S. Philip Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1946, at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15, 1945 to Dec 8, 1946 and that I last saw him alive on Dec 8, 1946

Immediate cause of death Pulmonary tuberculosis

Due to tubercular laryngitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pineane M.D.

Address Glen Dale, Md. Date signed 12/8/46

MARGIN RESERVED FOR BINDING

VS A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1946

BURFA 8

2-23

2-2430 — 2-10 ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

12333

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Pro Geo Co
City or town Riversdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Pro Geo Co
City or town Riversdale Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4801 Longfellow St
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

William F Sedwick

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marie I. Sedwick

6. (c) If alive, give age..... year

7. Birth date of deceased (mo., day, yr.) Oct 17, 1883

8. AGE: Years 63 Months Days It less than one day
..... hrs. min.

9. Birthplace Maryland
(City, town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Thomas Sedwick

13. Birthplace Md

14. Maiden name Mary Hooper

15. Birthplace Md

16. Informant Marie I. Sedwick

Address Riversdale Md

17. Burial Date thereof The 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location Washington D.C.

18. Funeral director F. Gasch's Sons

Address Hyattsville Md.

19. Dec. 23, 1946 to 46 Miss J. J. Severel
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1946, at 6p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/10 1946 to 12/20 1946
and that I last saw him alive on 12/20 1946

Immediate cause of death Lung carcinoma & metastases to cervical glands & liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George J. Hegener M. D. or other

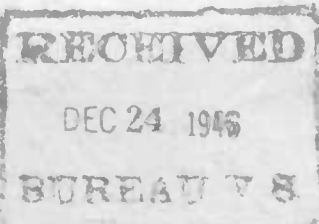
Address 3711-38th Ave Date signed 12/21/46

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25

2 - 2450

1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-2)

CERTIFICATE OF DEATH

12334

Reg. Dist. No. 2451

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 Yrs. 3 Mos.
 Hospital, institution, or street address where death occurred:
 Eugene Leland Memorial Hospital
 How long in hospital or institution?..... 2 Yrs. 3 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Prince Georges
 City or town..... Mitchellville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Margaret Virginia Smallwood

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Ryder Lee Smallwood

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... August 17, 1866

8. AGE: Years..... 80 Months..... 4 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Maryland (Town, county, and state)

10. Usual occupation..... Hswf.

11. Industry or business

12. Name..... John William Messick

13. Birthplace..... Maryland

14. Maiden name..... Alice Jane Jenson

15. Birthplace..... Maryland

16. Informant..... Hospital Records

Address.....

17. Burial Date thereof..... 12-28-46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Luke's Church

Location..... St. Luke's Church

18. Funeral director..... W. W. Chambers Co

Address..... 5501 Cleveland Ave. Riverdale Md

19. Dec. 26th 1946 10045 Severe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 25 1946 at 8:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to Dec 25 1946 and that I last saw him alive on Dec 25 1946

Immediate cause of death..... Cerebral thrombosis DURATION 4 mo.

Due to..... General arteriosclerosis with hypertension 10 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

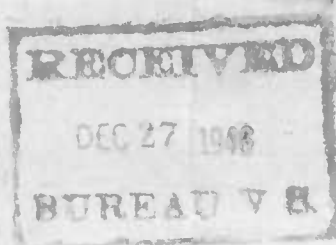
Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

L. W. Mullen M.D.

23. SIGNATURE..... 4404 Lawrence Rd. M. D. or other

Address..... Riverdale, Md. Date signed..... 12-25-46



1-25-

2-2450 ————— 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12335

★ Reg. Dist. No. 2420

1. PLACE OF DEATH:

County Prince Georges
 City or town Arson Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 years
 Hospital, institution, or street address where death occurred:
5701 - Livingston Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Arson Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5701 - Livingston Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war World #1

3.(a) FULL NAME

Raymond de Long Stockman

3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Lucy Stockman
 6.(c) If alive, give age 43 years
 7. Birth date of deceased (mo., day, yr.) Sept 13, 1889
 8. AGE: Years 57 Months 3 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Washington DC
 (Town, county, and state)
 10. Usual occupation Potest Attorney
 11. Industry or business
 12. Name Charles J. Stockman
 13. Birthplace Arlington, Columbia
 14. Maiden name Mary Carleton
 15. Birthplace Arlington, Columbia

16. Informant Lucy Stockman
 Address 5701 - Livingston Road, Arson Hill
 17. Burial Date thereof 12/17/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington Hall
 Location Arlington, Va.
 18. Funeral director Chambers Co
 Address 517 N St SE
 19. Dec. 16 19 46 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 46 at 6:15 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death Coronary occlusion
 Due to Cardiovascular renal disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

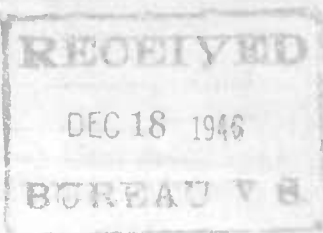
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Deputy medical examiner
Forestall M. Deor other _____
 Address Forestall Rd Date signed 2-15-46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-B

CERTIFICATE OF DEATH

12336

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mos., 25 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 9 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 832 5th Street, N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

SUGGS, LILLIE

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Jack Suggs
 6. (c) If alive, give age 38 years
 7. Birth date of deceased (mo., day, yr.) Jan. 7, 1909
 8. AGE: Years 37 Months 37 Days 11 If less than one day 10 hrs. 10 min.

9. Birthplace Wayne County, North Carolina
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Elbert Hunter
 13. Birthplace Wayne, North Carolina
 14. Maiden name Pennie Gordon
 15. Birthplace Wayne, North Carolina

18. Informant Deceased
 Address

11. Removal Date thereof 12-18-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory to work DC
 Location

18. Funeral director Johnson & Jackson
 Address 2053 1st Ave NW

19. 12-18 19. 46 Rowland C. Philips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 19. 46 at 6²⁰ p. m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/21 19. 46 to 12/17 19. 46
 and that I last saw h. cc alive on 12/17 19. 46

Immediate cause of death pulmonary tuberculosis
 DURATION 37 mos.

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane MD
 M. D. or other
 Address Glenn Dale, MD Date signed 12/17/46



2-25

2-2430-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ^{Correct age} is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

12337
Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
City or town Dupont Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Dupont Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alberta Thomas

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored married

6.(b) Name of husband or wife Frank Thomas

7. Birth date of deceased (mo., day, yr.)

1893B.(c) If alive, give age 54 years

8. AGE: Years 53 Months _____ Days _____ If less than one day
_____ hrs. _____ min.

9. Birthplace _____ (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Bonnie Clarke13. Birthplace Maryland14. Maiden name L

15. Birthplace _____

16. Informant Frank ThomasAddress Dupont Hghts Md.17. Burial Date thereof 1 3 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ForestvilleLocation Maryland18. Funeral director Arthur L. PollinsAddress 4339-Hunt Pl. NE

19. Dec. 31 19 46 Carrie F. Campbell.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 19 46 at 6:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 25 19 46 to Dec. 30 19 46
and that I last saw him alive on Dec. 30 19 46

Immediate cause of death

Cerebral Hemorrhage

Due to

Hypertension

Due to

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. T. Beedon MD M. D. or otherAddress 4423-Hunt Pl. NE Date 12-30-46

RECEIVED

JAN 2 1947

BUREAU 6

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

12338

Reg. Dist. No. 2320

1. PLACE OF DEATH:

County Prince Georges
City or town Croome
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

mt Calvert Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Croome
(If outside city or town limits, write RURAL and give nearest town)Street No. mt Calvert Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Vincent Alonza Tolson

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Eleanor Tolson

7. Birth date of deceased (mo., day, yr.)

September 18, 19118. (c) If alive, give age 33 years

8. AGE:

Years

Months

Days

If less than one day

35220

hrs.

min.

9. Birthplace

Upper Marlboro Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Robert Tolson

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mamie Gordon

15. Birthplace

Maryland

16. Informant

Eleanor Tolson

Address

Croome, Md

17. Burial

BurialDate thereof 12-14-46

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

St. Marks

Location

Croome, Md

18. Funeral director

Pittman Bros.

Address

Upper Marlboro, Md

19. (Date rec'd by registrar)

Dec 13 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....18....., 19....., 19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

acute congestive heart failure
Due to Acute Alcoholism

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Reputable medical exam23. SIGNATURE James J. [Signature]

M. D. or other

Address Forestville Md Date signed 12-11-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1251

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

DEC 17 1946

BUREAU 1.8

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12581

Reg. Dist. No.

2391

1. PLACE OF DEATH:

County Prince GeorgesCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Warrens Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town College Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 4510 Amburst Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mabel Travers

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James W. Travers

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 10, 18728. AGE: Years 74 Months 6 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace Philadelphia, Penna.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jesse Smallwood13. Birthplace Howard Co., Maryland14. Maiden name Frances Marshall15. Birthplace Howard Co., Maryland16. Informant Eugene TraversAddress 315 Montgomery Ave., Laurel17. Burial Date thereof 1-3-47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Ivy Hill CemeteryLocation Prince Georges Co., Maryland18. Funeral director Lloyd Kaiser, Inc.Address 381 Main Street, Laurel Md.19. 1-3 19 47 Core E. Wachter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 31 1946 at 5:2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 27 1946 to 12 31 1946and that I last saw her alive on 12 31 1946Immediate cause of death Apoplexy DURATION 12 27 46Due to Diabetes mel 2 yrs.Due to Hypostatic Pneumonia 3 d.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. P. Kern M. D. or other 1-2-47Address Laurel Md. Date signed 1-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTERIAL LEDGER

FOR CONTINUED

RECEIVED

JAN 13 1947

BUREAU

2-25

2-2390- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B10*

CERTIFICATE OF DEATH

12339

Reg. Dist. No. *2450*

1. PLACE OF DEATH:

County *Prince George*
 City or town *Hyattsville Md*
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: *Mother Jones Rest Home*
 Stay in hospital or inst. (yrs., or mos., or days) _____
 Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County _____
 City or town *Washington DC* Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. *2106 Bryant St NE*
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

William Walter Tucker

3. (b) Social Security Number

4. Sex *m.* 5. Color or race *w.* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Mary M Tucker*

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) *Aug. 24 1862*8. AGE: Years *84* Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace *Md.* (Town, county, and state)10. Usual occupation *Retired*

11. Industry or business _____

12. Name *J. I.*13. Birthplace *Md.*14. Maiden name *Susan F Tucker*15. Birthplace *Md.*16. Informant *James F Tucker*Address *2106 Bryant St NE*17. *Burial* Date thereof *Dec 13, 1946*

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Friendship Md*

Location _____

18. Funeral director *Deal Funeral Home*Address *4812 Ga Ave NW**Dec 11* *46* *James Sevey*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/10* 19*46* at *HP* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *8/1* 19*46* to *12/10* 19*46*and that I last saw him alive on *12/8* 19*46*Immediate cause of death *myocardial failure* DURATION *1 mo*Due to *Cardio-renal-vascular disease*

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE *R. H. Conkling MD* M. D. or other _____Address *3100 20th NE* Date signed *12/10/46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 12 1946

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

12340

Reg. Dist. No. 2451

1. PLACE OF DEATH:

County Prince George's

City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred:

3715 Volta Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1332 Newton N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clyde Wilbur Vance

3.(b) Social Security Number

579-01-1476

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Rebecca E Vance

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1909

8. AGE: Years 37 Months 3 Days 28
It less than one day
hrs. min.

9. Birthplace Brown's Summit, N.C.
(Town, county, and state)

10. Usual occupation Auto mechanic

11. Industry or business Humans Service Station

12. Name Charles W Vance

13. Birthplace N.C.

14. Maiden name Alta Pegram

15. Birthplace N.C.

16. Informant Rebecca E Vance

Address 1332 Newton St NE, DC

17. removal (Burial, cremation, or removal. Which?) Date thereof 12/4/46
(month) (day) (year)

Cemetery or crematory

Location Wash. D.C.

18. Funeral director Wm Lewis Sons Co

Address 3004 20th St NE Wash DC

19. Date rec'd by registrar Dec 14, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 18

Immediate cause of death

Myocardial infarction and shock

Due to Gun shot wound through heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 12-4-46

Where did injury occur? Brentwood P.D. Hall
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Post Office

Means of injury Shot self with .38 Smith & Wesson

23. SIGNATURE James J. Hall

M.D. or other

Address Brentwood Md

Date signed 12-4-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-25

2-2450 - 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince George's
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hrs

Hospital, institution, or street address where death occurred:

Pr. George General Hosp.
 How long in hospital or institution? 19 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. George
 City or town 1 Kaywood Gardens
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4200 29 St. apt. 7
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Waidlow, Mrs. Mary B

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 1 18898. AGE: Years 57 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Ga
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
 12. Name James Hughes
 13. Birthplace Ga
 14. Maiden name Ella McDaniel
 15. Birthplace Ga

16. Informant

Address

17. Burial Date thereof Dec 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory 7th Memorial CemeteryLocation Colmar Manor Md.18. Funeral director W. W. Chambers Co.Address 1400 - Chipping St. N.W.19. 25 76 Wanda Drury
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 25 19 46, at 7:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Dec 19 46 to 25 Dec 19 46
 and that I last saw her alive on 25 Dec 19 46.

Immediate cause of death Acute myocardial
Infarction

DURATION

48 hrs

Due to Coronary artery Disease 1+ years

Due to arteriosclerosis, generalized 2+ years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

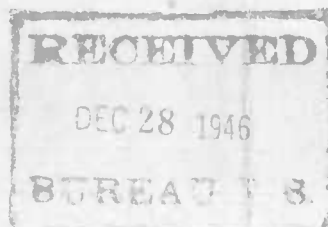
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel J. N. Sugar, M.D. M. D. or otherAddress 4300 Kaywood Drive Date signed 25 Dec 46
Mt. Rainier, Md.

12-25-46

Dr Lloyd notified @ 7³⁰/Am



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

12342

Reg. Dist. No. 2431

1. PLACE OF DEATH:

County Prince Georges
 City or town Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos., 5 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 732 LaMont St., N. W., Apt. 402
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

BESSIE WHITE

3. (b) Social Security Number

579-26-2217

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1912 6. (c) If alive, give age _____ years

8. AGE: Years 34 Months 10 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Orange Co., Virginia
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Daniel White
 13. Birthplace Orange Co., Virginia

MOTHER 14. Maiden name Clara Cooper
 15. Birthplace West Virginia

16. Informant Deceased
 Address _____

17. removal (Burial, cremation, or removal. Which?) Date thereof Dec. 21, 1946
 (month) (day) (year)

Cemetery or crematory Washington, D. C.
 Location _____

18. Funeral director R. L. M. Gure
 Address 1820 - 9th St. N.W. Washington, DC

19. Dec. 21, 1946 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1946 at 5:42 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/14/46 to 12/20/46 and that I last saw her alive on 12/20/46

Immediate cause of death Pulmonary tuberculosis DURATION 2 mo

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

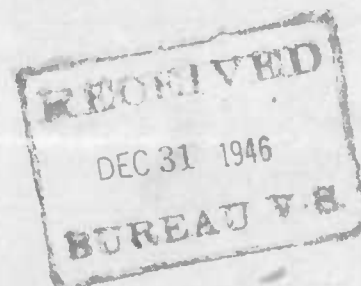
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane MD M. D. or other

Address Glenn Dale, Md. Date signed 12/20/46



2-2430- 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

12343

Reg. Dist. No. 2342

1. PLACE OF DEATH:

County pr eyes. to
 City or town Clinton Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County pr eyes to
 City or town Clinton Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

HATTIE E. WHITE

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Widowed6. (b) Name of husband or wife Berg. E. White7. Birth date of deceased (mo., day, yr.) June 30 - 18778. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Forestville, Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Christopher Moore13. Birthplace Md14. Maiden name Mary Elizabeth Burgess15. Birthplace Md16. Informant Aubrey B. WhiteAddress Clinton Maryland17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Dec 13 - 1946
(month) (day) (year)
Cemetery or crematory Christ Church Cemetery
Location Clinton Maryland18. Funeral director Thomas F. Murray Home
Address 2507- Nichols Ave SE

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 11 1946 at 4:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Dec 11 1946 and that I last saw her alive on Dec 10 1946Immediate cause of death Acute cardiac decompensation

DURATION

1 dayDue to General Arteriosclerosis and with Coronary ThrombosisunknownDue to an attack of angina3 mo.

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no
Accident, suicide, or homicide no Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury _____ Injured at work?

23. SIGNATURE Paul E. Van Hatten M. D. obstetricAddress 5440 Silver Hill Rd Date signed Dec 11 1946
Washington 19 DC1946 Dec 11 46 Thomas F. Murray Registrar
(Date rec'd by registrar)

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Diat. No. 12344 2310

1. PLACE OF DEATH:

County Ridge
 City or town Greensboro, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 hrs 35 min
 Hospital, institution, or street address where death occurred:
Prince George's General
Ofc. 35 min
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)
 State M.D. County Geo. Co.
 City or town 317 Pine Grove Dr. Maning Side Village
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Maning Side Village
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Herbert D. Whitner

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Jeanne Mary Whitner
 9.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 21 - 1871
 8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Concord, N. Hampshire
 (Town, county, and state)
 10. Usual occupation Florist
 11. Industry or business Flower

MOTHER FATHER
 12. Name Geo. L. Whitner
 13. Birthplace N. Hampshire
 14. Maiden name Caroline J. Gase
 15. Birthplace N. Hampshire
 16. Informant Mrs. J. Head
 Address 317 Pine Grove Drive S.E. Nat. Hl
 17. Burial, cremation, or removal, which? Burial Date thereof 12/25/46
 (month) (day) (year)
 Cemetery or crematory Geo. Wash. Mem. Ok. Cent.
 Location Ridgely Wood N.J.
 18. Funeral director Chambers Co.
 Address 5801 Cleveland Ave. Riverdale, Md.
 19. 12/24 46 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1946, at 7:35 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20, 1943 to Dec. 23, 1946
 and that I last saw him alive on December 23, 1946

Immediate cause of death hypostatic pneumonia
 Due to Brown atrophy heart
 Due to _____
 Other conditions Multiple thrombophlebitis
ileocolic & perimetral veins
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results Same
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?
 23. SIGNATURE William Brown
Capitol Hq. Md.
 Address _____ Date signed 12/31/46

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STANDARD INFORMATION SECTION

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

12345

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince Geo - HarpCity or town Cherry m.d.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Geo Harp Cherry m.d.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Pr GeoCity or town Long fellow Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 4571
(If rural, give LOCATION) appt 4

2.(a) If veteran, name war

3. (a) FULL NAME

Maddie G Wilcomb

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife Calvin Wilcomb

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov - 10 - 18828. AGE: Years 64 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace England
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Geo - Baker12. Name Geo - Baker13. Birthplace England14. Maiden name Hammish15. Birthplace England16. Informant Calvin WilcombAddress 4571 Long fellow Hyattsville, md17. Cremated Date thereof 12-20-46
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory St. Luke's ChurchLocation Wash. DC18. Funeral director Worsham's Co.Address Princeton, md.19. 12/20 19 46 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 19 46 at 11 9 15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to 12-20 19 46.and that I last saw him alive on 12-20 19 46.Immediate cause of death Carcinoma of lung DURATION 1 yr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jean Ann Harp M. D. or other _____Address Hyatts. Md Date signed 12-10-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORANDUM FOR THE SECRETARY OF DEFENSE

Subject: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

12346

Reg. Dist. No. 2420

1. PLACE OF DEATH:

County Prince George County
 City or town 6916 Lenwood Ave. Seat Pleasant, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ad. New York County Onieda
 City or town Seat Pleasant, Md Rome
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6916 Lenwood Ave. "A" St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war NONE

3. (a) FULL NAME

WILLIAM MOSES

WILLIAMS

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife HATTIE MAE BIGGS WILLIAMS6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) SEPT 14, 1876

8. AGE: Years 70 Months ✓ Days 15 If less than one day
hrs.min.

9. Birthplace Wales
 (Town, county, and state)

10. Usual occupation MECHANIC11. Industry or business AIR PLANE DEPOT12. Name UNKNOWN13. Birthplace WALES14. Maiden name UNKNOWN15. Birthplace WALES16. Informant Mr HOWARD M WILLIAMSAddress 6916 Lenwood Ave, Seat Pleasant Md.

17. Removal Date thereof Dec 1, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Oliver, New York18. Funeral director J. Arthur WaltersAddress 254 Carroll St. Takoma Park, D.C.

19. Dec 1, 1946 Registrar Carrie E. Campbell
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1, 1946 at 2 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 9, 1946 to Dec 1, 1946and that I last saw him alive on Nov 29, 1946Immediate cause of death Carcinoma of the stomach unknown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Superior the carcinoma found at wall. San Date of op. Aug 46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. Stedley M.D.Address 1452 1st St Date signed Dec 1, 46

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

CONFIDENTIAL

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

12347

CERTIFICATE OF DEATH

Reg. Dist. No. 2310

1. PLACE OF DEATH:

County Prince GeorgeCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 daysHospital, institution, or street address where death occurred:
Prince George General HospitalHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)Street No. 5637 Chesapeake Road
(If rural, give LOCATION) MD.

2(a) If veteran, name war.....

3. (a) FULL NAME

Andrew J. Wray

3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 1946 1889
6. (c) If alive, give age..... years8. AGE: Years 57? Months..... Days..... If less than one day..... hrs. min.9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name George Wray

13. Birthplace.....

14. Maiden name Unknown

15. Birthplace.....

16. Informant Mr. William BeechamAddress 5637 Chesapeake Road, Chesapeake17. Removal Date thereof Dec 11, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Rushmore Va.Location P.A. Tallant18. Funeral director 3619 - 14 2nd NWAddress 12/11 46 Amanda Dourney19. (Date rec'd by registrar) 12/11 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 December 1946, at 9:12 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Dec 1946 to 11 Dec 1946
and that I last saw him alive on 11th December 1946Immediate cause of death Subtotal Cholecystitis
Megacolon
Due to Adenocarcinoma of Colon

DURATION

Due to.....

Other conditions Adenocarcinoma of
esophagus
(Include pregnancy within 3 months of death)Major findings of operations Megacolon
Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE William Beecham
M. D. or otherAddress 1801 Eye St NW Date signed 11 Dec 46

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